Primary Care Case Management Options Strategy Group
Meeting Notes

July 31, 2002

I. Welcome and Introductions

Teresa Graves, co-chair, began the meeting with a brief review of the July 22nd Options Workgroup meeting regarding Mark Meiners suggestions for developing key components of care systems both within fully integrated care plans as well as through stand alone options.

The goal of the Primary Care Case Management strategy group is to design a feasible PCCM model for San Diego by taking into consideration the various resources and support needed as well as the risks, obstacles and benefits associated with such a system.

Participants in attendance: Karen Wilson, R.N., Jennifer Guthrie, Cheri Graham Clark, R.N., Stephanie Kearns, R.N., Vilma Maravilla, R.N., Julie Johnston, Teresa Graves, Betty London (substituting for Maxine Fischer), Burton Disner, Sara Barnett

II. Initial Group Discussion

The group used the MaineNet model presented by Dr. Meiners as a starting point for generating discussion. The Maine model is a voluntary, managed fee for service (FFS) program that offers primary care physician's (PCP) a $30 PMPM for case management. The contracting PCP is responsible for coordinating all the acute and primary care Medicaid services on a non-risk basis with a focus on managing pharmacy services. Centralized care coordinators support the role of the PCP through population-based interventions. There are 1200 beneficiaries participating (approximately 65% are dual eligible).

It was pointed out that this model has been successful because the Maine pilot sites are in heavy FFS markets. The San Diego health care environment differs in that is has a much higher managed care penetration rate compared to FFS. Additional drawbacks and lessons learned by the MaineNet model were discussed: high cost, change in model structure midstream. The Maine pilots are also serving a significantly smaller group compared to the 90,000+ dually eligible in San Diego. Thus, the feasibility of a large-scale PCCM program in San Diego is questionable and challenging. A small-scale pilot appears to be more realistic and could possibly be expanded based on evaluations and outcomes.

III. PCCM Advantages/Benefits:

- Vehicle to integrate acute, primary and LTC benefits – a real opportunity to improve quality of life for patients because PCCM responds to and meets needs of the patient rather than needs/wants of the healthcare system.
- Interdisciplinary care teams effectively and efficiently manage care across settings.
- Economic incentive – possible cost savings because there is less utilization when patients receive appropriate services.
- Does not restrain physician practice – few, if any, restrictions on services, conserves time, coordinates care with other providers, infrastructure already in place in some physician offices.
- Quality assurance, monitoring and controls built into system.
- Consumers involved in decision-making process.
- Uses consistent and standardized criteria (Medicare/Medicaid guidelines).

IV. PCCM Disadvantages/Obstacles:

- San Diego has a much higher managed care penetration rate compared to FFS.
- High cost; not budget neutral- how could this be funded considering the current state budget crisis?
- Time and Resource intensive -Are there enough case managers for this population?, -Who pays the case managers?, -How much does the PCP get reimbursed?, -Requires a tremendous amount of education, training and orientation for all involved.
- No clear incentive for PCP to willingly participate – difficult to get PCPs involved at any stage because case management never has been and never will be their primary focus.
- Physicians, consumers and other providers lack sufficient knowledge about LTC.

V. Assumptions for PCCM pilot in San Diego:

- Assuming 90,000 lives in San Diego and one case manager per 2500, would need 36 case managers at approximately $50,000/year for a total cost of ~$1.8 M (benefits, cost of initial assessment, and other operating expenses not included). Of the 2500 lives, it is assumed that approximately 1,200 of them would cycle through active case management for a short period of time in one year. Case management needs would be assessed up front and tiered based on risk and need for case management.

- Since the group did not know if the case manager salaries would be expected to be paid from the $30 PCP PMPM, the group assumed that this would be the case and suggested a PMPM spilt of $30 PMPM: $10 to PCP $20 for case management services.

- Role of PCP – responsible for consultation, pharmacy management, care plan review authorization.

- Multi-disciplinary team – MSW, RN, PCP. Assignment of case manager dependent on the current need of the client, location of client and/or location of physician office.
    - Use geo-map to locate clients and assign case manager by geographic area.
    - Group clients based on common physician or physician office

- Combination of on-site and telephonic case management.

- Point of entry - identify and seek out physician groups with a high Medi/Medi population and then stratify patient requirements for participation through screening process (i.e., survey or other method).

- The group underscored the need for top-of-the-line case management software that offers productivity management, disease state management, case management, referral, client option cost/benefit analysis and more.

- Screening process
    - County responsibility
    - Mass screening – 100% outreach
    - Separate cost from PMPM
    - Survey – determine criteria for high-risk clients (SNF certifiable) and either send to Medi/Medi population (Board and Care residencies (B&C), Single Room Occupancy hotels (SRO), HUD

- apartments, etc) or go out to selected MD offices to instruct them on program criteria & have them make referrals.
  - SNF eligibility – need to research specific criteria/guidelines currently being used.
  - Concerns with survey – mass mailing may not reach those who really need the services, PCPs may be biased in their referrals and may not actively engage in referral process, question of what to do with non-responders.

- Education/Information dissemination – maximize existing resources by brokering information with resources in community (mail, Internet, call center). Offer prevention and disease education to public.

- Assume that no new services will be purchased?????????

- Standardized training and orientation provided for case managers and PCPs so that all data and information consistent (contract out for this service).

- Establish Physician Advisory Board to get provider input.

- Manage productivity of case managers (outsource-software currently available).

- Designate Independent evaluator(s).

- Include pharmacy management component.

- Timeline: at least 2-3 years…possibly 4.

- Confidentiality/Privacy rights– each patient must sign consent to release/share information with providers.

- Oversight & monitoring - County responsibility (possibly contract with an outside agency that has experience integrating care for the Medi/Medi population)

- Desired outcomes and performance measures: adherence/compliance, improved quality of life, decreased utilization/readmission rates.

VI. Other elements/concerns:

- Does $20 PMPM for case management include oversight and administrative costs?
- Should the pilot be voluntary or mandatory? Would a voluntary pilot generate enough volume to make program financially possible? Would a voluntary population be biased? What are the regulatory requirements for mandating enrollment? Are there certain waivers needed? (Defer to Mark Meiners)
- What should the scope/size of the pilot be? (MM)
- Who would be the independent evaluator (s)? (MM, other)
- Literacy issue – use a combination of on-site and telephonic services to reach population with cognitive impairments or other language barriers.

VII. Adjourn

The meeting adjourned at 4:00 PM. A brief follow-up meeting will be held August 15, 2002 at 2:00 PM. Location – Sharp Health Care, Room 182.